Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

MFDR Tracking Number
M4-11-1535-02

Respondent Name
HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box
Box Number 47

MFDR Date Received
January 18, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated December 10, 2010: "The services were provided and the claims were denied per EOB based on extent of injury. The treatment that was provided is part of her compensable injury to her forearm that she sustained on 03/25/09. Also, denied per EOB based on the findings of a review organization. CPT code 97799 CPCA was preauthorized therefore it is deemed medically necessary. Last denial per EOB precertification/authorization exceeded. In summary, it is our position that Gallagher Bassett has established an unfair and unreasonable time frame in paying for the services that were medically necessary…"

Amount in Dispute: $11,531.25

RESPONDENT'S POSITION SUMMARY

Respondent's Dispute Packet Dated February 3, 2011: The respondent did not include a position summary with their response.

Response Submitted by: Gallagher Bassett, 6504 Intl Pkwy, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2009	Chronic Pain Management Program CPT Code 97799-CP-CA (7 hours)	$875.00	$0.00
December 21, 2009	Chronic Pain Management Program CPT Code 97799-CP-CA (7 hours)	$875.00	$0.00
December 22, 2009	Chronic Pain Management Program CPT Code 97799-CP-CA (7.25 hours)	$906.25	$0.00
December 23, 2009	Chronic Pain Management Program CPT Code 97799-CP-CA (7.25 hours)	$906.25	$0.00
January 14, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.75 hours)	$843.75	$0.00
January 19, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.25 hours)	$781.25	$0.00

January 20, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.5 hours)	$812.50	$0.00
January 26, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.25 hours)	$781.25	$781.25
January 27, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.5 hours)	$812.50	$812.50
January 28, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.5 hours)	$812.50	$812.50
March 2, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (4.5 hours)	$562.50	$562.50
March 3, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (7.5 hours)	$937.50	$937.50
March 4, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.5 hours)	$812.50	$812.50
March 5, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.5 hours)	$812.50	$281.25
TOTAL		$11,531.25	$5,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

This amended findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for chronic pain management programs.
3. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §137.1, effective January 18, 2007, provides the Disability Management Guidelines to resolve medical benefit disputes.
5. 28 Texas Administrative Code §137.100, effective January 18, 2007, are the treatment guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 7, 2010, January 28, 2010, January 30, 2010, February 4, 2010, and February 9, 2010
   - 216 – Based on the findings of the review organization.

   Explanation of benefits dated January 8, 2010
   - 16 –Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated January 12, 2010, January 14, 2010, February 19, 2010, March 15, 2010, and March 23, 2010,
   - 19 – (198) Precertification/authorization exceeded.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated February 5, 2010, February 20, 2010, March 16, 2010, April 7, 2010, April 17, 2010, and May 14, 2010
   - 219 – Based on extent of injury.

Issues

1. Does an extent of injury issue exist in this dispute?
2. Does a preauthorization issue exist in this dispute?
3. Is the requestor entitled to reimbursement for CPT code 97799-CP-CA?

Findings

1. On April 22, 2009, the carrier filed with the Division a form disputing any diagnosis other that the sprain/strain to the right forearm was related to the compensable injury.

   According to the explanation of benefits, the respondent denied reimbursement for the chronic pain management program billed under CPT code 97799-CP-CA based upon reason code "219-Based on extent of injury".

   A Contested Case Hearing (CCH) Decision was issued on January 17, 2012 that found "The compensable injury of March 25, 2009 does not extend to and include a right shoulder rotator cuff injury with SLAP lesion and cervical sprain/strain."

   A review of the medical bill finds that the requestor billed the disputed treatment for diagnosis code 841.9-Sprain/strain unspecified site elbow/forearm. Therefore, an extent of injury issue does not exist in this case.

2. 28 Texas Administrative Code §134.600(q)(5) states "The health care requiring concurrent review for an extension for previously approved services includes: (5) chronic pain management/interdisciplinary pain rehabilitation."

   On February 22, 2010, the respondent gave preauthorization for five additional chronic pain management treatment sessions, to be performed between January 25, 2010 and March 25, 2010.

   The preauthorization report does not define the five pain management sessions as calendar days or as an 8 hour sessions. Therefore, the Division will rely upon the Official Disability Guideline, ODG, for guidance.

   The ODG, refers to a chronic pain management as "Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed)."

   The Division concludes that preauthorization was obtained for five full-day (40 hours) sessions or the equivalent in part-day sessions rendered from January 26, 2010 through March 5, 2010. The remaining four and a quarter hours on March 5, 2010 exceeded the preauthorized services. No reimbursement is recommended for services rendered December 18, 2009 through January 20, 2010 because they were not preauthorized.

3. 28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   >
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP-CA for forty hours as stated above from January 26, 2010 through March 5, 2010. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x forty (40) hours = $5,000.00. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $5,000.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $5,000.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		1/10/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.